

**PERCEPTION OF PREGNANT WOMEN ABOUT THE ATTENTION RECEIVED AFTER
DECENTRALIZATION OF PRE-NATAL CARE**

PERCEPÇÃO DA GESTANTE SOBRE O ATENDIMENTO RECEBIDO APÓS DESCENTRALIZAÇÃO
DA ATENÇÃO PRÉ-NATAL

PERCEPCIÓN DE LA MUJER EMBARAZADA SOBRE LA ASISTENCIA RECIBIDA DESPUÉS DE LA
DESCENTRALIZACIÓN DE LA ATENCIÓN PRENATAL

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ABSTRACT

Objective: To know the perception of pregnant women about primary care after decentralization of prenatal assistance. **Method:** Descriptive, exploratory research with qualitative approach. Eleven pregnant women users of the Unified Health System of the municipality of Mandaguari, Paraná, participated in the study. Data were collected between July and August, 2017, through individual interviews in the ward of the nursing unit of the Basic Health Unit with application of a semi-structured questionnaire. Interviews were audio recorded, transcribed and submitted to Content Analysis in the thematic modality. **Results:** The following categories emerged from the analysis: "Satisfaction of the pregnant women with the care received from professionals during prenatal care" and "Critical nodes of care after the decentralization process". **Final considerations:** It was observed that, according to the perception of the pregnant women, the actions to prenatal care after the decentralization process occurred without standardization among the different Basic Health Units, with individual aspects of professional attitudes and qualification as factors that interfere with the quality of care.

Descriptors: Perception; Pregnant women; Prenatal care; Decentralization; Primary health care.

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RESUMO

Objetivo: Conhecer a percepção da gestante sobre o atendimento na atenção básica após a descentralização da assistência ao pré-natal. **Método:** Pesquisa descritiva e exploratória de abordagem qualitativa. Participaram 11 gestantes atendidas pelo Sistema Único de Saúde do município de Mandaguari, Paraná. Os dados foram coletados entre julho a agosto de 2017 a partir de entrevistas individuais, realizadas na sala da consulta de enfermagem da Unidade Básica de Saúde, com a aplicação de um questionário semiestruturado. O áudio de cada entrevista foi gravado, transcrito e submetido à Análise de Conteúdo, modalidade temática. **Resultados:** A partir da análise dos dados emergiram as seguintes categorias: "Satisfação das gestantes frente o atendimento recebido pelos profissionais da saúde no pré-natal" e "Nós-críticos do atendimento após o processo de descentralização". **Considerações finais:** observou-se que, segundo a percepção das gestantes, após o processo de descentralização as ações de atenção ao pré-natal ocorreram de maneira não padronizada entre as diferentes Unidades Básicas de Saúde, sobressaindo aspectos individuais de postura e qualificação profissional como interferentes na qualidade do cuidado. **Descritores:** Percepção; Gestantes; Cuidado Pré-natal; Descentralização; Atenção primária à saúde.

RESUMEN

Objetivo: Conocer la percepción de mujeres embarazadas sobre la asistencia en la atención básica tras la descentralización del cuidado prenatal. **Método:** Investigación descriptiva y exploratoria, de abordaje cualitativo. Participaron 11 mujeres embarazadas acompañadas por el Sistema Único de Salud de Brasil en la ciudad de Mandaguari, Paraná. Los datos fueron recogidos entre julio y agosto 2017, a partir de entrevistas individuales, realizadas en el despacho de la enfermera de la Unidad Básica de Salud, con la aplicación de un cuestionario semiestruturado. El audio de cada entrevista fue gravado, transcrito y sometido al Análisis de Contenido, modalidad temática. **Resultados:** los análisis de los datos identificaron las siguientes categorías: "Satisfacción de las mujeres embarazadas frente la atención recibida por los profesionales sanitarios en el prenatal" y "Nodos críticos de la atención tras el proceso de descentralización". **Consideraciones finales:** se observó, según la percepción de las mujeres embarazadas, que después del proceso de descentralización las acciones de atención al prenatal ocurrieron de manera no estandarizada entre las diferentes Unidades Básicas de Salud, destacándose aspectos individuales de postura y calificación profesional como interferentes en la calidad del cuidado. **Descriptor:** Percepción; Mujeres Embarazadas; Atención Prenatal; Descentralización.

INTRODUCTION

The decentralization of the public health system occurred in a gradual manner, making Brazilian municipalities responsible for the health care of their inhabitants. This action caused great changes from the institutional, managerial, political and financial point of view. With this process, each municipality of the country had to create a management structure, the Municipal Health Department, to implement health services even in places where, until then, there was no health unit, and also to participate in health care financing. This process is

completed and today the more than 5,500 Brazilian municipalities are responsible for the primary health care of their inhabitants⁽¹⁾. However, the characteristics of the country - the large territorial extension and persistent social, salary and educational inequalities and problems of political management - have made this process of decentralization to take place differently in the various municipalities of the country and even between the different health care programs in the same municipality.

Among the ministerial programs, the maternal-infant area has always been a priority. Of particular note are the Wo-

men's Health Integral Care Program (PAISM), created in 1983; the Comprehensive Child Health Care Program (PAISC), created in 1985; the Family Health Program implemented in 1994, that is not specific to this area but has brought great improvements in health care for women and children; the National Program of Humanization of Labor and Childbirth created in the year 2000; and the National Policy of Humanized Attention to Low Birth Newborns - Kangaroo Method, created in 2007.

Following a chronological sequence, in 2011, the network of maternal, neonatal and infant care, called the Stork Network, was created as a program that incorporated all the previous actions, to guarantee access, embracement and resolution in the care to labor and childbirth, the growth/development of children up to 24 months and access to reproductive planning. Another important action was the launch of the National Guidelines on Caesarean Section and Normal Birth in 2015 and 2017, based on the methodology and guidelines of the National Institute for Health and Care Excellence (NICE) of the UK National Health System⁽²⁾.

The implantation and expansion of these programs has reflected in reduced maternal mortality, which was 140 deaths per 100,000 live births (LB) in 1990, changing to 62 deaths per 100,000 LB in 2013⁽³⁾, thus representing an improvement in obstetric care. However, despite this reduction, Brazil did not achieve the established goal of 35 deaths per 100 thousand LB, the second in the list of the Millennium Development Goals for 2015. It is also worth noting that, despite the decrease of the rate of maternal death due to direct obstetric causes, that is, those that appear during pregnancy, childbirth and puerperium, these still represent the main cause of death⁽⁴⁾. This finding demonstrates the seriousness of this event, considered a serious public health problem.

In this sense, the implementation of public policies aimed at pregnant women has allowed greater accessibility to the early initiation of prenatal care through the decentralization of care, contributing to the improvement of the indicators. Basic Health Units (BHUs) should work as

the first point of the care network used by pregnant women to access the health system. Basic Health Units are therefore a strategic point of attention to better meet the needs of these women, providing longitudinal and continuous follow-up, mainly during pregnancy⁽⁵⁾.

Quality prenatal care at the system's entry point is critical to maternal and fetal health, as it can promote a healthy pregnancy and minimize the risk of complications and/or death during pregnancy and childbirth for the mother/child binomial. It is noteworthy that quality health care and access to the system, especially to prenatal, childbirth and puerperal care, have an impact on reducing maternal and perinatal mortality, provided the pregnant women seek these services and adhere to treatment. Thus, humanized prenatal care and establishment of a bond facilitates the adherence and continuity of prenatal care⁽⁴⁾.

It is worth considering that pregnancy is a complex experience with different aspects for each woman and, therefore, the assistance should be individualized. Besides the biological dimension, pregnancy is a social process that involves collective aspects, mobilizing the family and the environment in which the women are inserted. The involvement of women, their partners, the family and the health services is important for health promotion, disease prevention and early detection of risk situations to occur safely.

Considering that the process of decentralization of care should contribute to a greater link between pregnant women and professional teams and facilitate access to prenatal, and also that the process of decentralization of prenatal care occurred three years ago in the city studied, the objective of this research was to know the perception of pregnant women about the attention received in primary care after the decentralization of prenatal care.

METHODS

This is a descriptive and exploratory study with a qualitative approach in Basic Health Units of the Municipality of Mandaguari. This municipality has a

population of 34,289 inhabitants⁽⁷⁾ and belongs to the 15th Regional Area of Health of the state of Paraná. The network of assistance to pregnant women counts on a private hospital, an emergency unit, and six Basic Health Units (BHUs) that offer prenatal care for pregnancies of habitual risk and two Clinics for Women's Care that offer prenatal care for intermediate risk and high risk pregnancies. The decentralization of care for the Basic Health Units occurred three years ago; before that, care was concentrated in the two reference clinics.

To participate in the study, the pregnant women should meet the following inclusion criteria: to be attended exclusively by the Unified Health System in one of the BHUs of the municipality under study, regardless of their gestational age and habitual risk. In turn, women with communication and/or cognitive problems that impeded the understanding of the questionnaire and compromised the provision of information were excluded.

Data collection took place between July and August 2017, through an individual interview with the application of a semi-structured questionnaire with open and closed questions, and the following question: How do you perceive prenatal care received in the Basic Health Unit in which you are being followed-up? The interviews took place in the nursing consultation rooms of the BHU, were audio recorded and had an average duration of twenty-five minutes. After records, the interviews were duly transcribed in order to obtain the trustworthiness of the answers.

For data analysis, the steps established by the methodological framework were: pre-analysis, material exploration and data processing. In the first step, the empirical material was organized, transcribed and sorted; then, a quick reading was made to identify the emerging and relevant aspects to meet the objective of the study. In the second step, a process of classification and data aggregation was carried out through careful reading, with color identification of the common and specific aspects, giving rise to previous categories. Finally, in the third step, the categories were deepened

through the empirical articulation of the data with the theoretical material⁽⁸⁾.

Ethical aspects were respected, including the submission of the study to the Standing Committee on Ethics in research involving human beings of the State University of Maringá, which was approved under Opinion 648/2009. All participants signed two copies of the Informed Consent Term (ICF) and were identified by parity, followed by the age of the interviewed pregnant woman, as for example: PW1 P0, 20 years old.

RESULTS

Knowing the research subjects

Eleven pregnant women aged between 17 and 35 years were interviewed; the majority (seven) was between 20 and 29 years of age. As for ethnicity, the majority (eight) considered themselves white and the other brown skinned. The schooling of the pregnant women was concentrated between 5 and 9 years of study (seven); the minority (two) had from 1 to 5 years of schooling and other two had from 10 to 12 years of schooling. As to occupation, five were inserted in the labor market and the others considered themselves "housewives". Regarding the marital status, five pregnant women maintained a stable union, five were married and one was single. The most prevalent family income was between one and two minimum wages, and four women reported a family income of less than one minimum wage, and two between 3 and 5 minimum wages.

The analysis of the interviews with the subjects allowed the organization of the discourses in two thematic categories: "Satisfaction of the pregnant women with the care received from professionals during prenatal care" and "Critical nodes of care after the decentralization process".

Satisfaction of pregnant women with the care received from professionals during prenatal care

In this category, it was observed that the pregnant women were satisfied with the care received from health professionals of the Family Health Strategy (FHS) during prenatal care. They even demonstrated that they knew the

professionals who assisted them and were content with the way the service was conducted, especially with the clarification of doubts and the fact that they did not have to wait to be assisted. This can be seen in the following statements:

"I like it because here I already know all the nurses, the physician, everything here is good" (PW1 P0, 17 years old).

"The doctor is great, she explains everything, clarifies my doubts and the consultation is always at the scheduled time" (PW1 P0, 25 years old).

Another important aspect was related to the link between health professionals and the pregnant women; this aspect was highlighted as an important tool for establishing and maintaining the relationship professional/patient. This relationship proved to be supported by trust and respect.

"Ah, it [the assistance] has been good, because the doctor, the nurses always treat me well" (PW1 P0, 21 years old).

"[...] I really like the doctor. The way they treat us; always so politely and attentive." (PW1 P0, 25 years old).

It was observed that the pregnant women interviewed were followed-up by a multiprofessional team formed by physicians, dentists, nurses, physical therapists and community health agents, each one exercising its function in a collaborative sense.

"[...] Yes, here we receive care from the physician, the social worker, the dentist, the psychologist and the nurses. I was well assisted, well attended; many people came to see me" (PW2 C1, 30 years old).

"[...] the CHA gave me excellent guidance, the physician and my physical therapist who is an angel" (PW2 C1, 30 years old).

The statements of the pregnant women also showed that they perceived that the professionals of the FHS are well prepared to carry out their work, mainly because they are able to clarify their doubts during prenatal care. This led to the understanding that prenatal follow-

up, with the general practitioner only, can be effective.

"[...] The consultation could only be given by the clinician; he is well prepared and he answered all my questions and helped me a lot too" (PW1 P0, 17 years old).

"[...] They answered all my questions, they helped me a lot and they explained to me very well what I was supposed to do during my gestation so that I my pregnancy progressed well" (PW1 P0, 17 years old).

"[...] For me, it is good with the clinician, I there is no complication, nothing, there is no reason, she always answers my questions, she never left me with doubts, the guidelines she would give me she did give me; she always asked the due tests in the months" (PW1 P0, 25 years old).

The interventions of the professionals involved in prenatal care, especially of physicians, nurses and nutritionists, according to the reports of pregnant women, showed a focus on guidelines for healthy eating, with information provided in a clear and accessible manner, as observed in the following lines:

"The nurse advised me on various topics, because although I had been pregnant before, everything was different. Wow! she helped me a lot, guided me on how to eat, I wasn't eating correctly, I was had a lot of difficulty in that part" (PW3 C2 35 years old).

"So he guided me about some things, I gained weight, I went over the limit; then he referred me to a nutritionist and she is giving me much guidance on healthy eating. The doctor gave me advice; anyone else did" (PW2 C1 23 years old).

It was noticed with the statements of the deponents that the form of care provided is different between the different Basic Health Units of the municipality; some pregnant women reported receiving guidance only from the physician and others indicated that the guidelines were provided by physicians and nurses and other professionals of the multiprofessional team.

The pregnant women also pointed out that they received guidance, essential in the process of health education, in various opportunities such as during

consultations in Basic Health Units or home visits by FHS professionals.

"[...] Yes, those girls who came, the Health Agents, they always come here to see how I am" (PW3 C2, 35 years old).

"[...] Yes, the physician, the social worker, the dentist, the psychologist and the nurses. I was well assisted, well assisted; many people came to see me" (PW2 C1, 30 years old).

In short, in this category, it was possible to observe that the close attention from FHS professionals facilitated by home visits and the consultations in the Basic Unit strengthened the professional/patient bond. These aspects associated to the opportunity to be assisted by a multiprofessional team and the receipt of understandable guidelines, with real clarification of questions, proved to be fundamental aspects for the satisfaction of the pregnant women regarding the assistance received.

Critical nodes of care after the decentralization process

Some pregnant women were dissatisfied with the fact that care was not provided by the obstetrician. This is because they believed that a specialized training would offer higher quality care to the mother-child binomial, and also that the professionals should have the possibility to dedicate exclusively their attention to the needs of the parturients.

"[...] "The physician, all he can do he did. So, having no obstetrician at the beginning is ok. But, later, I think it would be better to be seen by an obstetrician; I think it would be better" (PW2 C1, 30 years old).

"[...] It is clear that if an obstetrician was available, it would be better, it would be a more specific attention for the baby, it would be great if we had an obstetrician in the unit; it would be much better, because the general practitioner does everything, but an obstetrician would give more specific attention for the pregnant women" (PW2 C1, 30 years old).

The dissatisfaction of some pregnant women with the lack of preparation and/or lack of interest of some physicians of the FHS during the prenatal consultations was evident. The following

statements describe the failure to perform simple and fundamental procedures for the evaluation of the pregnant women, deeming this evaluation as an exclusive practice of nursing.

"[...] You come to a general practitioner, and the only thing he does is to look at you and say "You're fine". He does not measure the belly, he does not do anything. Who does that? The nurses, and I do not agree with that" (PW3 C2 35 years old).

The lack of preparation and posture of the professionals can generate a feeling of insecurity in the pregnant women who need their care. According to the reports, the physician of one of the FHS teams consulted the cell phone whenever a question was made, and he did not prescribe basic supplements for prevention of gestational anemia.

"[...] Look, I'm going to be honest, I evaluate the assistance I've received as bad, because everything you go to asks the physician he looks at his cell phone; so, if I were to come to a physician who would look on the cell phone to find the answers, I would do that myself at the home, typing my question on Google®, I do not know where he looks, but you ask him something, it takes a year to respond and he looks at his cell phone, then after an hour he'll answer your question. I had varicose veins in my leg, so I told him and he said he cannot do anything about it. Then he talks about the socks; my luck is that I had a pregnancy before and the other gynecologist was out spoken, I learned a lot, but I think if it was the first pregnancy I would be very confused, because everything you ask he does not know how to answer; you see that he had no confidence to speak to you" (PW2 C1, 23 years old).

"[...] There was a time when I had anemia too and nobody told me, I found out in the company, I came and I had to take ferrous sulfate that was mandatory to be taking and the physician had not told me or prescribed that; I think an obstetrician I would be more attentive to this point" (PW3 C2, 35 years old).

In the perception of pregnant women, the form of organization of the agenda in the BHU is another point that does not work well in the service. They are unable to have consultations with the physician who is accompanying their prenatal care in situations of intercurrents; they have

rather to look for Emergency Care units of the municipality in these situations.

"[...] The routine consultations are scheduled, but if in the meantime you do not feel well, it's difficult there, you have to go to an ECU (Emergency Care Unit); the problem is that you get there at the ECU, it's not the same care for a pregnant woman like here, right? One of these days, I felt a strong pain in the spine, I even went there in the ECU but they could not do anything" (PW2 C2, 35 years old).

In this category it was possible to see obstacles that hamper the quality of care including non-specialized training and lack of preparation of FHS physicians to perform basic obstetric care procedures. The discontinuation of care in situations of interurrences also emerged as a fragility of the care according to the perception of pregnant women.

DISCUSSION

The perception of the pregnant women about the prenatal care was related to the bond they establish with the professionals and the perception of their technical-scientific preparation, be it the obstetrician, the team of the Reference Unit, the general practitioner in Basic Health Units or other members of the Family Health Strategy. It was observed that the decentralization of prenatal care in the city studied showed inconsistencies among the Basic Health Units, making individual characteristics of the professionals stand out in the prenatal care program as a whole.

It is noteworthy that prenatal care is a set of preventive and curative measures, with the purpose of providing welfare conditions for pregnant women and their babies, ensuring the birth of healthy children with minimal risks for the mothers, and valuing the technical-scientific competence of each member of the multiprofessional team. To do this, prenatal care can be performed directly by the physician, obstetrician or FHS physician and/or nurses and can also count on the participation of other professionals such as nutritionists, social workers, dentists and psychologists⁽⁹⁾.

Thus, within the multidisciplinary team, each professional has a role in

integral and quality care. In this perspective, good care results from the interest shown in the physical examination and in the questions asked, as well as the provision of clear guidelines that meet the expectations of women. Still, the resolution of the adopted behaviors and the interpersonal relationship established between professionals and patients are considered, demonstrating preparation and respect for pregnant women.

Another context⁽¹⁰⁾ points out that the perception of pregnant women in the health service is also related to the time dedicated to consultations; it was almost unanimous opinion of women that professionals should dedicate more time to them. When these characteristics are not considered in the conduct of FHS professionals, the medical-centered model focuses on the specialties stand out. It was noted in this study that the pregnant women who reported that they preferred to be accompanied by an obstetrician in a reference unit were the same ones who presented complaints of lack of preparation of professionals and of link with the FHS team.

It is worth considering that the model adopted in Brazilian health is still curative and overvaluing medical specialties⁽¹¹⁾. A strong resistance to change the model of care was observed in the statements of some pregnant women, where other types and forms of health care are understood as secondary. However, it was evident that the acceptance or not of the pregnant women by the general practitioner was related to the way the professional rendered care.

In this sense, attention is drawn to the quality of care offered, especially in the gateway to health services. In this instance, aspects that go beyond biological needs must be considered, so as to strengthen the relationship between professionals and the pregnant women and their families. Studies on prenatal care carried out in several Brazilian settings indicate or allow to infer that, in medical and/or nursing consultations, reproductive health needs have generally been approached from an exclusive biological perspective, and that it is necessary to enhance the inclusion of socio-cultural and psych-emotional aspects⁽¹²⁾; this is facilitated when care is

provided by FHS professionals, because their work dynamics involve greater proximity to individuals, families and the community.

There is consensus in the literature that the adherence of pregnant women to the health service and the quality of care provided prevent maternal deaths. For this, political, economic, social and cultural factors can determine the adequate health care, depending on the adherence of women to prenatal care. Health professionals are therefore the ones who can effectively improve the reality as maternal mortality can be avoided by simple measures to ensure the quality of health care and guarantee access to these services⁽¹³⁾.

In this sense, the actions of a team of health professionals contribute to the achievement of these goals. A multidisciplinary quality care is capable of promoting actions that enable pregnant women to understand the changes of their body, the whole gestational development, thus helping in the promotion of health, preventing eating, psycho-affective and sociocultural disorders⁽¹⁴⁾.

Care begins in traditional units such as Family Health Units (FHUs), with the embracement that initiates this approach where health professionals are in direct contact with pregnant women and are consequently able to narrow the ties and gain their trust and collaboration⁽¹⁵⁾. However, the reception in health units is usually limited to an activity of receiving and sorting spontaneous demand⁽¹⁶⁾. When obstacles to access and impersonal care exist, they provoke users' dissatisfaction⁽¹⁷⁾, which was also demonstrated in this study when the pregnant women needed to use Emergency Care Units for emergencies.

Likewise the reception in the FHU, home visits facilitate and collaborate for ease of access and bond of the community with the team. The implementation of a home visiting program during pregnancy is mainly a comprehensive strategy to prevent adverse outcomes of childbirth⁽¹⁸⁾. A study conducted in Japan to assess whether home visits by public health nurses to high-risk pregnant women prevented adverse outcomes at

delivery showed that such visits were effective in preventing preterm birth⁽¹⁹⁾.

A strategy adopted in Brazil to guarantee the quality of prenatal care was the National Program of Humanization of Labor and Childbirth that provides guidance on the fact that it is a duty of the unit and of health professionals to receive pregnant women and their relatives with dignity and respect, accompanying them throughout gestation until birth⁽²⁰⁾. Such a program emphasizes the importance of health professionals to consolidate educational activities during the follow-up of pregnant women, either individually or in groups, as these actions can provide moments of experience, feelings and difficulties, as well as decrease the asymmetry in the relationship of pregnant women with health services, improving the quality of care⁽²¹⁾. In this study, it was observed that this strategy was not implemented by the FHS teams as stated by the study participants, thus demonstrating the team's fragility in health prevention and promotion actions.

FINAL CONSIDERATIONS

The results of the present study show that the process of decentralization of prenatal care occurred in a heterogeneous way in the different Basic Health Units of the municipality investigated, generating discrepancies in the perceptions of pregnant women about the care provided. The opinion varied from positive aspects that reflect competence and the humanized and respectful attention, to the lack of preparation of some professionals that weakened the service rendered.

The critical nodes identified after the process of decentralization of care were the discontentment of some pregnant women because the care was not performed by obstetricians; lack of preparation of FHS physicians that impaired the link of trust between the users and the service. The reports did not show the existence of groups of pregnant women, which are fundamental for the continuity of care.

Finally, it should be noted that this study has limitations. Among them is the fact that the pregnant women were

interviewed within the Basic Health Unit in which they receive care, which could result in a research bias because they might be inhibited to expose their actual opinion about the health service and care. Therefore, opportunities for future research are opened aimed at contem-

plating the perception of pregnant women interviewed in places where they do not receive care such as in their own home, giving them greater freedom to talk about the care received. This would allow a greater reflection on the performance of health professionals in prenatal care.

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